of teaching and learning with each patient seen that is important. In a sense that is true for common illness but not when one wishes to learn about the less common disorders. The larger, especially public, institutions have the advantage, evidence for this being beyond the scope of this communication.

How then can a public teaching hospital cope with this increasing financial strain and yet preserve its graduate education programs? One possible solution might be that as private teaching hospitals reduce their care to the poor and uninsured patients, they must also reduce or eliminate their graduate teaching programs. Some of the funds saved could be redistributed to public teaching hospitals for their graduate education activities which might include sending their trainees to private institutions for portions of their training. This is already being done effectively by many academic health centers and medical schools. Additional financing for graduate medical education could be provided by any or all of the following: (1) The private sector and all health insurance programs should be asked to participate in this function, not just federal, state and local governmental agencies. (2) Although politically unpopular, all alcohol, tobacco and ethical drug products should be taxed, with the proceeds earmarked for health care, a portion of which could be used to support graduate medical education. (3) The academic health centers should seek private funding through grants and endowments to support graduate medical education to the same extent that research support is now funded.

As in all other fields of medical care, graduate medical education is not only being subjected to programmatic stresses but is also being threatened by economic hardship. Characteristically, the academically affiliated public hospitals are experiencing the greatest negative impact. Measures must be taken by all those concerned in order to preserve the high quality of training programs from which this country has benefited for many years.

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Medicare-Funded Cardiac Transplants

TO THE EDITOR: The article by Renlund and associates in the May issue[1] details the successful experience of a cardiac transplant center that would not qualify for funding under Medicare's proposed guidelines.

We are specifically concerned that the designation of *only* a few centers will have an adverse effect on other successful programs. If third-party payers adopt these recommendations and only reimburse at those federally designated centers, 76 of the 86 centers that presently perform cardiac transplantation would not be able to continue to do so. Further, with the low minimal survival rates that have been recommended, and the three-year length of time for a program to prove itself successful, we feel the Department of Health and Human Services is inappropriately emphasizing the quantity of transplants performed versus the quality or survival rates of different programs.

As one of the four most active cardiac centers in California, our program has performed 18 transplants over a 19-month period with a 100% survival rate to date. We have worked diligently at establishing a multidisciplinary and successful cardiac transplant program that is committed to serving the people of San Diego County. In addition, a coordinated research effort at our institution to define noninvasive immunologic and hemodynamic correlates of transplant rejection has already yielded published results. We feel that our success in cardiac transplantation has important positive input both on health care delivery in our region and on transplantation in general.

We hope that Medicare closely evaluates their proposed guidelines before making them final, thus avoiding a negative impact on many programs. Highly successful transplant programs should continue to be supported.

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Heart Disease and Mortality

TO THE EDITOR: Regarding the recurrent discussion concerning dietary cholesterol in atherosclerosis, the most recent iceberg tipped on pages 621-622 in your May 1987 issue of the journal.[1,2] Both Dr Wolfstein and Dr Desmond are correct. Dr Desmond thinks she answers Dr Wolfstein's caveat by quoting the consensus conference in December 1984, and she quotes them accurately—that is, that they talked about "heart attacks." These data are now rather firm, especially with reference to the most recent study presented in the *American Journal of Cardiology* a year ago.[3]

Dr Desmond, however, incorrectly extrapolated the statement on heart attacks to mortality in her article in the January 1987 issue.[4] This is where Dr Wolfstein is right. Coronary artery disease mortality has not as yet been documented to be reduced by cholesterol lowering.

Pearce and Dayton many years ago in the Veteran's Administration Hospital study at Los Angeles showed that the death rate stayed about the same over a five-year study.[5]

Once again, arteriosclerosis is "the blindman and the elephant."[6]

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Physicians and the Death Penalty

TO THE EDITOR: In her article on "Physicians and the Death Penalty,"[1] Dr Thorburn raises issues that should not be ignored by any physician. Her assertions regarding the role of medical examiners deserve comment. In the most extreme position detailed in her article, Dr Thorburn implies that *any* involvement by physicians in *any* phase of a case leading to execution is unethical. This would mean that medical examiners should not examine homicide victims because of the potential for a death sentence. As medical examiners it is our responsibility to document injuries and present our findings in an honest and unbiased manner. In this we act as the advocate of the murder victim, not as an agent of the court. Our testimony can exonerate an innocent suspect as well as implicate the guilty. If we were to stop examining homicide victims there is the potential that our lack of involvement could lead to the death of an innocent person, a much more untenable ethical position.

In the case of medical examiner involvement after an execution we once again must act as the advocate of the deceased person. It is our duty to assure that the executed person has no injuries other than those which were legally sanctioned. Without our involvement there can be a question in the minds of the deceased's relatives as well as society as a whole as to whether the ultimate and irreversible sanction has been fairly and justly administered. It is our belief that to ban all participation of physicians in death sentence cases would raise greater ethical issues than it resolves.

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TO THE EDITOR: Dr Thorburn's "Informed Opinion" in the May issue of the journal[1] seems both informed and, quite clearly, an opinion. Her material is carefully arranged and very well documented, but the conclusion suffers from the incongruity that is unavoidable when attempts are made to apply pure idealism to an imperfect society. It is neither possible nor ethically defensible to declare that physicians must refuse to be involved in the insoluble problem of capital punishment. If more than 70% of the US citizenry views the death penalty as necessary for societal protection, it will certainly see to it that "dangerous" persons are executed, whether or not physicians choose to participate.

It is quite clear that society is not capable of controlling the small percentage of its members who are bent on destroying others. Because methods of incarceration are fallible and because it is quite clear that sociopathic personalities cannot be rehabilitated, execution looms as the logical, if unpleasant, societal recourse. It is specious to argue that it should not be done because it offends our sensibility or is often done imperfectly. Let those who argue so skillfully and emotionally that the death penalty is improper suggest a practical and reliable alternative to the control of persons like Ted Bundy, who have the form of humanity without a shred of human sensitivity, who are frighteningly skillful at escape and manipulation of the legal system and who have no allegiance whatsoever to the Universal Declaration of Human Rights.

Our recognition of rights and the commonality of basic human values constitute excellent guidelines for solving the majority of society's problems. But there are no rules that are applicable in every situation, and Dr Thorburn's proposal that it is unethical and indefensible for any physician to "participate in any act connected to and necessary for the administration of capital punishment" will create more problems than it will solve in our real world, where the issues present themselves in shades of gray. No amount of wishful thinking and idealistic pronouncement will convert them to black and white.

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Opposing Views on Deaths From Firearms

TO THE EDITOR: The March issue of the journal contains, under the heading "Special Article," an article with the strange title of "The Epidemiology of Firearm Deaths Among Residents of California."[1] This article not only lacks any scientific premise, but contains some gross errors of fact. Firearms deaths no more have an "epidemiology" than baseball bat or butcher knife deaths. This article is clearly an undisguised antifirearms propaganda piece having no place in a putative scientific journal. In the first paragraph the authors refer to "more than 30,000 Americans" alleged to die as the result of gunfire. The last figures I have seen, derived from the 1985 FBI annual report, indicates less than 20,000 firearms deaths, and it is imperative that this be understood to include all categories of firearms deaths including suicide and accidents. I am giving these numbers strictly "off the cuff" without available reference sources here in my office, but I am generally quite familiar with the numbers concerned here. My figures are approximations from memory. The under 20,000 figure above is correct as stated. As I recall, about 8,000 of these are suicide. Suicide is a psychiatric and psychologic problem, not a matter of methodology. Reference to firearm suicide is clearly a non sequitur, and I would only point out in passing that Japan, which virtually prohibits private ownership of firearms, has a far higher suicide rate than the United States, where in most localities firearms can be obtained with little difficulty and complicated impedances in others, which do not seem to affect suicide rates.

As I recall, some 3,000 or so firearms deaths are accidents. Accidents mostly happen as a result of ignorance or carelessness, whether we are talking about automobiles, lawn mowers, chain saws or firearms. It may be worth mentioning that there has never been a fatal accident to my knowledge on a firearms range operated by a rifle or pistol club affiliated with the National Rifle Association, clearly indicating that proper training and proper use is the answer here. It is also pertinent that the last fatality figures I have seen by the Na-